MC0332

NATIONAL AUDIT OFFICE

Report by the Comptroller and Auditor General

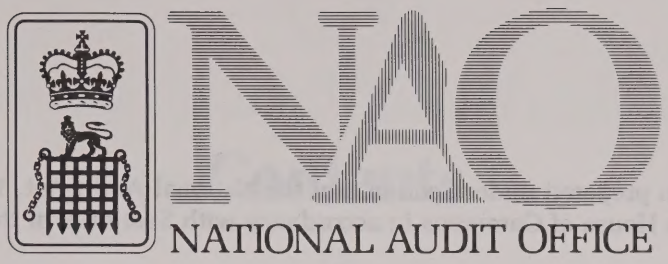
Estate Management in the National Health Service

Ordered by the House of Commons to be printed
28 March 1988

Her Majesty's Stationery Office, London
£3.80 net

405

PLEASE RETURN TO:
SUE - ROOM 306C E.T.



Report by the Comptroller and Auditor General

Estate Management in the National Health Service

Ordered by the House of Commons to be printed
28 March 1988

Her Majesty's Stationery Office, London
£3.80 net

405

This report has been prepared under Section 6 of the National Audit Act, 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General

National Audit Office
15 March 1988

The Comptroller and Auditor General is the head of the National Audit Office employing some 900 staff. He, and the NAO, are totally independent of Government. He certifies the accounts of all Government departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies use their resources

Contents

	Pages
Summary and conclusions	1
Part 1: Introduction	6
Part 2: The Estate Data Base	8
Part 3: Rationalisation and Disposal of Surplus Land and Buildings	12
Part 4: Development of Strategies for Maintaining the Retained Estate in an Adequate Condition	18
Glossary of abbreviations	23

Contents

	Page
Summary and conclusions	1
Part 1: Introduction	6
Part 2: The Estate Data Base	8
Part 3: Rationalisation and Disposal of Surplus Land and Buildings	12
Part 4: Development of Strategies for Maintaining the Retained Estate in an Adequate Condition	18
Glossary of abbreviations	23

Summary and conclusions

1. The National Health Service (NHS) estate is a vast resource. In England it comprises over 50,000 acres of land and some 2,000 hospitals, with a current value estimated at some £13 billion. Associated revenue costs in England exceed £1.5 billion a year. In recent years health authorities have been encouraged to dispose of surplus property and sales are likely to exceed £240 million in 1987–88.

2. In 1983 the Department of Health and Social Security (DHSS) published a report they had commissioned into "Underused and Surplus Property in the NHS" (the Ceri Davies report). The report, which dealt with the NHS in England, revealed that information was lacking on the amount of property held, its value, use and condition. Valuable resources were being wasted by under-use of space and by retention of surplus property. The report also expressed concern over the accumulation of backlog maintenance then estimated at about £2 billion. It concluded that NHS managers needed to have a greater awareness of the value of the estate and to consider estate matters when planning their strategy for health care.

3. This report presents the results of an examination by the National Audit Office of the measures adopted by DHSS, the Welsh Office and the Scottish Home and Health Department (SHHD), and the action taken locally by health authorities to ensure that the NHS estate is properly managed. The NAO sought to identify whether health authorities and boards had:

(a) established a reliable estate data base;

(b) determined their estate requirements and had identified the scope for the disposal of surplus property;

(c) developed strategies to bring the retained estate to an adequate condition and maintain it at that level.

Estate data base

4. On the first issue — whether health authorities and boards had established reliable data bases — the NAO found that:

In England

(a) property records were largely complete and valuations had been carried out in 1985 (paragraph 2.3);

(b) condition surveys had been undertaken but they were not always accurate and consistent (paragraphs 2.5–2.6);

(c) few districts had completed surveys of the suitability and use of buildings but where these had been undertaken they had demonstrated scope for significant savings through improved efficiency (paragraphs 2.8–2.12);

(d) little progress had been made on identifying and estimating the cost of work required to enable NHS buildings to comply with statutory and non-statutory building standards (paragraphs 2.13 – 2.14);

In Wales

(e) property records maintained at national and local levels were in some respects either incomplete or out of date (paragraph 2.15);

(f) although condition surveys had been undertaken, comparatively little progress had been made on establishing other information about the estate (paragraphs 2.16 – 2.18);

In Scotland

(g) scope existed to improve the property records maintained locally and by the Central Legal Office of the NHS (paragraph 2.19);

(h) the current market value of property was not generally available (paragraph 2.20);

(i) the SHHD had carried out a 10 per cent sample check on the results of local condition surveys completed in 1980 – 81, but have not yet undertaken checks on the findings from similar surveys commissioned in 1986 (paragraph 2.21);

(j) not all health boards had used the results of appraisals in 1980 – 81 of the suitability of property (paragraph 2.22);

(k) comprehensive surveys of the use of space had not been carried out and there was evidence that not all existing property was being used efficiently (paragraphs 2.22 – 2.23).

5. Systematic and reliable information about the estate is fundamental to its efficient management. It is also vital to service planning and making best use of the land and buildings. All three health departments had recognised earlier deficiencies in local arrangements and had taken steps aimed at ensuring that the necessary improvements were made. But it is clear that in many important respects progress has been slow and that a reliable data base has yet to be fully established. The failure to assess the extent to which NHS properties comply with statutory and non-statutory building standards represents a serious shortcoming. This has implications for the safety of patients and employees. Neither the health departments nor the individual authorities and boards have estimated the cost of bringing NHS properties up to these standards; but this cost must run into many millions of pounds.

6. Action needs to be taken to tackle the shortcomings in the estate data base without further delay. This should include the strongest possible encouragement by health departments and the provision of appropriate guidance where this remains to be issued. Meanwhile, the absence of a reliable data base is a serious impediment to rationalisation; and there is a danger that wrong disposal decisions could be made.

Rationalisation and disposal

7. On the second issue — whether health authorities and boards had determined their estate requirements and had identified the scope for the disposal of surplus property — the NAO found that:

In England

(a) there is considerable scope for further economies from such property rationalisation and one-fifth of districts confirmed that at least 40 per cent of their land was disposable (paragraphs 3.4 – 3.7);

(b) many existing rationalisation schemes were dependent on major capital developments and therefore the rate of implementation had been slow (paragraph 3.9);

(c) some authorities had drawn up proposals for new developments without knowing if they were making the best use of existing facilities (paragraph 3.10);

(d) an authority which had rationalised the use of buildings following property surveys had achieved substantial capital and revenue savings (paragraphs 3.11 – 3.12);

(e) rationalisation schemes had been held up by lack of funds (paragraph 3.13);

(f) proceeds from disposals had increased substantially over the last five years and may exceed £240 million in 1987 – 88. However, the DHSS were concerned about the realism of regions' disposal programmes and were not sure whether these represented satisfactory performance (paragraph 3.15);

(g) health authorities had experienced difficulties with planning and Green Belt restrictions and these had caused problems and delays (paragraphs 3.17 – 3.18);

(h) districts visited regarded the arrangements for the retention of sale proceeds in their regions as a disincentive to property disposals (paragraph 3.19);

In Wales

(i) some districts had experienced difficulty in disposing of properties, and this had given rise to additional maintenance and security costs (paragraph 3.23);

(j) some surplus land had been retained for long periods on the advice of the District Valuer in the hope that sale values might improve (paragraph 3.24);

(k) the pace of disposal had improved where this was an integral part of the planning process and use had been made of outside specialists (paragraph 3.25);

In Scotland

(l) the absence of comprehensive information about the estate and the fact that strategic planning had not yet been developed to a fully integrated stage had been an impediment to rationalisation (paragraph 3.26);

(m) the level of disposal proceeds in 1986 – 87 fell short of the SHHD's target mainly because of delays with one large sale. As a consequence of this slippage, the SHHD expect that the 1987 – 88 disposal target will be met (paragraph 3.28);

(n) some disposals had been substantially delayed (paragraph 3.29).

8. There is a risk that surplus property may be retained unless authorities and boards examine the use of buildings and rationalise their holdings as part of their strategic planning. All three health departments view rationalisation as a high priority task and consider that surplus NHS property is still held. A measure of rationalisation has taken place in recent years and the annual proceeds from disposals have increased significantly. However, decisions have often taken place in the absence of a reliable data base and outside the strategic planning process. Overall, the NAO were not convinced that the full potential for rationalisation had yet been identified.

9. Where concerted efforts had been made to rationalise facilities speedily substantial revenue savings and disposal proceeds had been achieved without full scale capital development. At Merton & Sutton, annual revenue savings from three rationalisation schemes amounted to around £1.8 million and disposal proceeds of some £9.8 million had been achieved or were in prospect.

10. It is disappointing to note the NHS Property Adviser's view that there is little evidence of the Merton & Sutton approach working smoothly elsewhere. The NAO note that potential revenue savings are at least as important as capital receipts from disposals. In this context, the DHSS have estimated that annual revenue savings from making better use of the estate may range betwen £300 million and £500 million.

Strategies for the retained estate

11. On the issue as to whether health authorities and boards had developed strategies to bring the retained estate to an adequate condition and maintain it at that level the NAO found that:

In England

(a) the DHSS have not monitored the level of expenditure required to clear backlog maintenance and do not know if the position has improved or deteriorated since it was assessed at £2 billion in 1982 (paragraph 4.4);

(b) over half of the authorities who had made returns have not met the DHSS target for the proportion of the estate that should be in at least adequate condition (paragraphs 4.6 – 4.7);

(c) local management was concerned about the safety and wider value for money implications of delays in undertaking maintenance work (paragraphs 4.9 – 4.10);

(d) most of the regional plans and programmes had failed to indicate the extent to which estate considerations had been integrated with service plans and little progress had been achieved in preparing comprehensive estate control plans (paragraph 4.13);

(e) in 1987 the DHSS monitoring arrangements had reported weaknesses in estate management including the quality of resources being applied to the work in some authorities (paragraph 4.15);

(f) previous shortcomings in the training arrangements had been addressed but attendance by health authority staff at relevant courses was low (paragraphs 4.16 – 4.17);

In Wales

(g) backlog maintenance continued to be a problem and existing minimum expenditure levels may be too low to cover maintenance requirements (paragraph 4.18);

(h) shortcomings in strategic planning for the estate mirrored those identified in England (paragraph 4.20);

In Scotland

(i) despite a special allocation of funds to tackle backlog maintenance a survey in 1986 indicated that the level had increased, and the SHHD acknowledged that until 1987 their monitoring of the special allocation has been inadequate (paragraphs 4.21 – 4.22);

(j) the lack of integration of estate management into the strategic planning process is a weakness (paragraph 4.23).

12. It is evident that backlog maintenance remains a serious problem. It is made worse by the maintenance liabilities which attach to the retention of property which is surplus to NHS requirements. The pace of rationalisation thus impacts on backlog maintenance. The NAO appreciate that estate maintenance has to compete for the available NHS funds. It is thus of crucial importance that planning is sound and fully integrated so that resources may be used to best effect. The availability of sufficiently senior and adequately trained staff at appropriate levels is also vital. Weaknesses in training arrangements coupled with low take-up therefore represent serious impediments to efficiency.

General conclusions

13. All three health departments recognised some years ago that the management of the NHS estate represented a problem area and they took positive action. Although progress has been made, it is evident that as regards the establishment of the data base, rationalisation and disposal of surplus property and the maintenance of the retained estate, the pace has been slow and much remains to be done.

14. In the NAO's view there is an urgent need for health departments to place renewed emphasis on the importance of addressing existing problems. A determination to drive change through at the local level and a more positive recognition of the estate as a resource are essential to this process. The NAO identified clear evidence of good local practice which demonstrated what can be achieved, particularly as regards rationalisation. Until the range of problems identified in this report have been overcome there will be continuing failure to achieve good value for money.

Part 1: Introduction

1.1 In England there are some 2,000 hospitals and numerous other buildings, and the estate comprises more than 50,000 acres. Most property was built before 1948 when the NHS was formed with over a third dating from the last century. The capital value of land and buildings in England in 1985–86 was estimated at approximately £13 billion, whilst the sites alone were worth well in excess of £4.5 billion. Associated revenue costs are in excess of £1.5 billion a year, or approximately 7 per cent of the total health budget. Thus, on average, a District Health Authority (DHA) in England maintains an estate of over 250 acres and incurs associated revenue costs of nearly £8 million a year on property valued at around £70 million.

The Ceri Davies Report

1.2 In 1983 the Department of Health and Social Security (DHSS) published a report that they had commissioned on "Underused and Surplus Property in the NHS" (the Ceri Davies report). The report, which dealt with the NHS in England, concluded that there was a lack of appreciation of the value of the estate. There were deficiencies in the management of NHS property and a need for property to be recognised as a key resource in the planning process. Valuable resources were seen as being wasted by the under-use of space in buildings and by the retention of surplus land and property.

1.3 More specifically, the report recommended that health authorities maintain a complete record of the value and physical state of all properties, the costs of operation, their suitability for their purpose and of the effective use of space. This would enable health authority managers to identify under-utilised parts of the estate and to determine those sites best suited for their purpose and those which should be disposed of.

1.4 The report concluded that on completion of property appraisals health authority managers should prepare estate control plans containing a record of the key decisions reached, costed and programmed. The report made a number of proposals aimed at estate rationalisation and maximising the proceeds from property disposals, including more vigorous pursuit of planning permission and the employment of specialists in commercial property matters. It also recommended that improvements should be made in the arrangements for training staff in estate management. The Enquiry Team expected that most of their recommendations could be implemented within two years of publication of the report.

1.5 The DHSS and the Welsh Office accepted the thrust of the report and both departments have subsequently introduced a number of measures aimed at improving estate management. The Ceri Davies report did not cover the NHS estate in Scotland but the Scottish Home and Health Department (SHHD) have recognised the need for effective management of the estate.

Health Departments' responsibilities for estate management

Department of Health and Social Security

1.6 Since the Ceri Davies report was published the DHSS have redefined departmental responsibilities to emphasise the importance of estate management. The Department see their role as increasing the awareness in health authorities of property as a resource; improving the effectiveness of disposal arrangements; and assisting the NHS Management Board in holding Regional Health Authorities (RHA) accountable for their management of the estate. The Department's role also extends to exploring improved methods or property management and issuing guidance as required in association with the Advisory Group on Estate Management, a joint DHSS and NHS body.

1.7 In November 1983 the DHSS instructed health authorities to take immediate action on the findings of the Ceri Davies report. In 1986, the Department reinforced their earlier instructions by announcing a structured framework aimed at systematic rationalisation of the estate:

(a) the establishment of a minimum estate data base;

(b) an analysis of the use, condition and performance of the estate;

(c) the achievement of maximum rationalisation of the estate consistent with service strategies;

(d) the evaluation of alternative options for the estate as part of strategic and operational service planning;

(e) the preparation of an investment programme reflecting service and estate plans;

(f) the preparation of an estate control plan for each site;

(g) the preparation of an estate operational plan to implement the control plan.

1.8 The DHSS monitor the activities of health authorities through planning and review procedures under which the authorities prepare and submit for approval long-term (strategic) plans and short-term (operational) programmes. The DHSS hold RHAs accountable through annual Ministerial Reviews and, since 1986, short-term performance has been examined through a system of Performance Reviews. In 1987 these were combined into a single system. In 1983 the Department said they would monitor implementation of the Ceri Davies report through this accountability review process.

The Welsh Office

1.9 In Wales overall responsibility for the NHS lies with the Secretary of State for Wales and the Welsh Office, with health care being administered by nine DHAs. The Welsh Office have placed responsibility for effective management of the estate with DHAs. Against this background the Welsh Office determine strategic policies, set key objectives, and in turn monitor and review the performance of health authorities against strategic plans and operational programmes. In addition the Welsh Health Common Services Authority (WHCSA) provide some estate management services including maintenance of property records.

1.10 In 1984 the Welsh Office instructed districts to compile a data base and to prepare estate control plans. Further instructions aimed at a structured framework to estate rationalisation, similar to those introduced by DHSS, were issued by the Welsh Office in September 1987.

The Scottish Home and Health Department

1.11 The NHS in Scotland is within the overall responsibility of the Secretary of State for Scotland and is administered centrally by the SHHD, and locally by 15 health boards. Whilst the SHHD have not specifically asked health boards to apply the Ceri Davies recommendations they issued broad instructions in 1984 aimed at improving the management of the estate. These required health boards to take steps to ensure that land and buildings are managed efficiently, that the use of property is kept under continuous review and, after formal review of all land held, that surplus holdings are identified and disposed of quickly. These instructions were reinforced in 1986 when the SHHD expressed concern that, notwithstanding the increase in the amount of surplus land identified, health boards still possessed property not essential to running the service. The Department's planning and review procedures now require health boards to incorporate estate rationalisation proposals.

Scope of NAO examination

1.12 Against this background, the NAO set out to consider the measures adopted by the health departments and the action taken locally to ensure that the NHS estate is properly managed. In particular, the NAO sought to identify whether health authorities and boards had:

(a) established a reliable estate data base;

(b) determined their estate requirements and had identified the scope for the disposal of surplus property;

(c) developed strategies to bring the retained estate to an adequate condition and to maintain it at that level.

1.13 The Committee of Public Accounts (PAC) considered the specific question of energy conservation in the NHS (22nd Report of Session 1984–85 and 42nd Report of Session 1985–86). Consequently, this matter has been excluded from the present NAO investigation.

1.14 In addition to enquiries within the three departments, NAO staff visited two RHAs and six DHAs in England, two DHAs in Wales, two Health Boards in Scotland and the NHS Training Authority as follows:

	RHA	DHA
England	West Midlands	Worcester
		Central Birmingham
		SE Staffordshire
	North Western	Oldham
		Lancaster
		W Lancashire
Wales		East Dyfed
		Mid Glamorgan
Scotland		Lothian Health Board
		Grampian Health Board

The NAO also made enquiries at East Anglia RHA and Merton & Sutton DHA.

Part 2: The Estate Data Base

2.1 Reliable information on the composition, condition, suitability and use of NHS property is fundamental to its efficient management. Moreover, such a data base stimulates an awareness of the opportunities and ways in which the estate can best be managed to meet service needs.

2.2 The NAO set out to examine whether a reliable estate data base had now been established. In particular, the NAO looked at what health authorities and boards had done to create reliable property records; to ensure that information on the physical condition, sutiability and use of buildings was held and reliably maintained; and that the estate complied with statutory and non-statutory standards.

Audit findings

England

Property records

2.3 The NAO examination at six DHAs showed that property records were largely complete and up to date. Valuations of property had been undertaken in 1985 and health authorities had recently been asked to arrange for them to be updated. Districts informed the NAO that they considered the valuations provided the broad indication of value necessary for health care planning. When properties were considered for disposal they sought more accurate and up to date assessments or expert advice.

Condition Survey

2.4 The Ceri Davies report considered that up to date information on the physical condition of the NHS estate was fundamental to its effective management. The DHSS asked DHAs to carry out property surveys by June 1984 and to keep building records up to date. Regions were asked to co-ordinate the work and ensure that a common basis was used.

2.5 The NAO found that all the district authorities visited had undertaken condition surveys of their properties. These had generally been carried out soon after the DHSS instructions had been issued in 1983. The NAO noted that all 14 RHAs were able to report to the DHSS in their 1985 Strategic Plans that condition surveys had been completed. However, the NAO found evidence to doubt the accuracy and consistency of the survey data in some instances:

(a) although North Western RHA had expressed doubts over errors and omissions from the survey in at least one of their districts, the NAO found that the overall consistency of the surveys had not been fully evaluated until 1987. However, the RHA had recently recognised the subjectivity of the condition surveys and they had established a District/Region working party to improve the quality and consistency of the survey information. They had taken action to place responsibility for updating the information on one officer within each district to provide greater consistency. They were also considering further measures including sample inspections by regional officers to verify districts' assessments of condition;

(b) consultants commissioned to undertake the 1983 – 84 survey in one district in West Midlands RHA had acknowledged that their appraisal had been a visual 'broad brush' inspection; that examination of the external fabric and roof of the buildings had been carried out at ground level; that not all the rooms had been surveyed; and that there had been double counting of some repair estimates;

(c) at two of the six districts visited local management had disagreed with original assessments and had made significant amendments to the condition profile of individual buildings, and in one of the cases, of the complete district.

2.6 The NAO examined the local efforts to reappraise regularly the condition of the estate and to update records. They found, for example:

(a) only two of the six districts visited had carried out annual reinspections of the complete estate;

(b) the 22 DHAs in West Midlands RHA had been encouraged to resurvey their estate but it was not until 1986 – 87 that they were formally required to do so. By March 1987, the majority of districts had still to start this work;

(c) although North Western RHA had regularly drawn to the attention of their disticts the need for condition surveys to be updated, the action taken by one district the NAO visited fell short of full reappraisal and failed to take account of further deterioration in property.

The NAO noted that only three of the 14 RHAs had recognised in their 1985 Strategic Plans the need to keep this information updated.

2.7 The NAO also examined whether health authorities held annual statements of the costs of operating property, including maintenance and replacement measures undertaken in the year. Although much of the necessary information was maintained, the NAO found that it was not generally brought together by estate managers and was not used for decision-making and monitoring purposes.

Surveys of suitability and use of buildings

2.8 The 1983 Ceri Davies report and the November 1983 DHSS instructions recommended that surveys of the suitability and use of buildings should be undertaken as soon as practicable. In view of the value of the estate and its associated running costs, these surveys are essential for achieving the best use of NHS properties. However, when the NAO examined local records they found:

(a) of the 22 districts in West Midlands RHA only two had fully completed the surveys, although three others had surveyed individual hospitals;

(b) in 1984, North Western RHA had attempted a broad assessment of the suitability and use of buildings within each district. However, the exercise did not meet the level of detail envisaged in the Ceri Davies report. Consequently DHAs had not used the findings as a basis for management decisions.

2.9 The importance of space surveys as a management tool was demonstrated by Central Birmingham DHA. In connection with the rationalisation of obstetric and gynaecology services, consultants reported surplus space amounting to 20 per cent of ward areas. At the time of the NAO audit these findings were being used by management to help decide whether a new development was necessary.

2.10 The DHSS had issued instructions to health authorities in 1983 regarding the need to undertake surveys of suitability and space use. They then undertook to issue guidance shortly and DHAs were expected to complete their reviews within one year of its receipt. Guidance had still not been issued formally at the time of the NAO audit. In their 1985 Strategic Plans three RHAs indicated that they were attempting to develop their own procedures and four others emphasised the urgent need for guidance before they could made progress in this area. The NAO noted that North Western RHA had developed and issued its own guidance in 1987 and set each of their DHAs a target for completion of the surveys by March 1988.

2.11 The NAO also visited East Anglia RHA to examine a regional initiative in this key area of property management. In 1985–86 the RHA had commissioned consultants to carry out comprehensive surveys across the whole region and the work was completed by February 1986. On the suitability of property the consultants reported that about 17 per cent (136,000 sq m) of the region's estate was either unacceptable or totally unsuitable for its current purpose. Their estimate of the cost of effective improvements was in excess of the £36.5 million. The region informed the NAO that a significant part of this amount was covered by capital developments included in their current strategic programmes.

2.12 The consultants' report also indicated that some 19 per cent of space was generally underused or unused, and about 18 per cent was overcrowded, overloaded or facilities overstretched. The NAO found that the survey results had not so far been used locally. But the RHA told the NAO that it was too early to evaluate their impact or the benefits likely to accrue. The region planned to review the position in two years' time to assess what had been done to improve the use of the estate.

Compliance with statutory and non-statutory standards

2.13 Health authorities must meet certain statutory building requirements in areas such as fire safety and kitchen hygiene. The NHS has Crown exemption from some statutory standards. The DHSS have instructed that these, and other non-statutory requirements (eg to avoid the spread of Legionnaires disease), must also be met. It is important therefore, for health and safety reasons, that health authorities identify and undertake the work required to comply with standards. In 1983 and again in 1986 the DHSS asked health authorities to assess the extent to which buildings complied with statutory and non-statutory standards and to indicate the costs of bringing property up to an acceptable level. Both RHAs visited by the NAO confirmed that none of their DHAs had complied with the DHSS requests, although North Western RHA expect that surveys, due to be competed by March 1988, will provide much of this information.

2.14 The latest (1985) regional strategic plans showed that only Yorkshire RHA had investigated the extent to which statutory requirements were being met. They had estimated that their districts needed to spend £3.6 million just to meet fire and safety standards. The next round of strategic planning will

probably be launched in 1989, but no firm date has yet been agreed.

Wales

2.15 As regards property records, the NAO found that the WHCSA maintain Land and Property Portfolios which are broadly equivalent to the records kept by RHAs in England. Copies of these portfolios are held at DHAs for the day to day management of the estate. However, at Mid Glamorgan, the NAO found that the portfolios had not been completed for hospital properties. More generally, the NAO observed that the Welsh Office Internal Audit had reported in March 1986 that the portfolios kept by the WHCSA were out of date. The WHCSA estimate that staff costs of around £40,000 a year would be incurred in undertaking the necessary work. These funds have now been made available and the Welsh Office expect all portfolios to be completed by September 1989.

2.16 Valuations of property had been undertaken in Wales in 1984 and updated during 1987–88. In the intervening years, where properties were scheduled for disposal, updated valuations had been sought. The NAO examination of the planning and review process confirmed that condition surveys had been completed in all Welsh DHAs. These surveys had been carried out by professionally qualified NHS staff or by private consultants, and the Welsh Office told the NAO that they had no reason to suppose that the condition surveys were unreliable. Accordingly, the Welsh Office have not undertaken any validation checks despite the subjectivity of surveys of this type.

2.17 The Welsh Office instructed districts in 1984 to review the suitability and effective utilisation of space within their buildings, and stated that guidance would be issued shortly. The absence of formal guidance was pointed out by the Welsh Office Internal Audit in 1986 and its issue remains outstanding pending promulgation by DHSS. Five of the nine Welsh DHAs have decided to await guidance before surveying the suitability and use of their buildings and as a consequence have yet to take any action. Neither of the two authorities visited had undertaken suitability surveys. Nevertheless, despite lack of guidance two authorities had completed suitability reviews and work was well advanced in two other authorities by January 1988. More generally, the picture that emerged from the NAO review of the planning and review process in Wales suggested that districts had concentrated on completing condition surveys and had made comparatively little progress with the remainder of the data base.

2.18 The NAO noted that until September 1987 the Welsh Office had not issued instructions to DHAs specifying the need to comply with statutory standards. Consequently the acountability process did not show the extent to which standards in Wales had been met. The NAO noted, for example, that East Dyfed had taken positive action to identify areas which did not comply with fire safety and hygiene regulations. However, they told the NAO that funds were insufficient to make an immediate impact on deficiencies identified.

Scotland

2.19 The SHHD maintain close relations with health boards. They have applied a less structured approach to estate management than in England and Wales and have placed few specific estate data requirements on boards. However, they have stressed the broad need to establish and maintain reliable information and have monitored progress directly through specific returns. The SHHD maintain property records as part of their estate management function. They recognise that these need to be improved and are in the process of doing so. The NAO examination also showed that the NHS' Central Legal Office, who hold the Title Deeds, have experienced problems in tracing deeds and in determining boundaries partly because of shortcomings in their records. Although they see scope for improvement, some of these problems are possibly unavoidable in view of the wording of title deeds and the length of time properties have been held.

2.20 Valuations for rating purposes were carried out in 1985. However, the SHHD take the view that current market valuations would not be justified for all NHS property because of the greater costs involved in Scotland (where there is a different valuation system) and that such information is not needed for service planning purposes. The SHHD normally expect boards to obtain valuation only where this is important for a specific capital expenditure or disposal decision.

2.21 A comprehensive condition survey of the NHS estate in Scotland was undertaken in 1980–81. Validation checks amounting to 10 per cent were applied by the SHHD and substantial changes made in the overall assessment of condition, but in some respects the survey remained unreliable. In one exceptional case, a major hospital block in the Greater Glasgow Health Board was declared operationally sound and in adequate condition. But the health board subsequently undertook urgent and major evacuation of patients for safety reasons. Over a period of years water seepage had caused severe structural damage to masonry and roof timbers and the hospital may now be demolished. At the SHHD's

request all health boards took steps during 1986–87 to resurvey their properties. At the time of the NAO study the SHHD had not received responses from all health boards and had not decided whether to undertake validation checks. The Department had, however, asked health boards to confirm that they were satisfied that appraisal procedures were adequate to identify defects of the type which had occurred in Greater Glasgow.

2.22 An appraisal of the suitability of property had been completed by all Scottish health boards in 1980–81. However, at one of the two health boards visited by the NAO the information collected had not been used. The NAO noted that health boards had been required by the SHHD in 1984 to keep under continuous review the use made of space in all property. But surveys had not been carried out for the complete estate at either of the two health boards visited. Lothian Health Board acknowledged, though, that surveys of suitability and space use are essential if the NHS is to make efficient use of the estate.

2.23 More generally, a Scottish NHS review team reported in 1987 on the use of land, buildings and equipment by health boards. They had found instances where accommodation was empty or only partly occupied. The review team concluded that the use of land and buildings in the NHS in Scotland had developed historically and had not been subject to review. Accommodation was not always being used efficiently and a review was required. The review team recommended that health boards should identify any partially occupied or vacant accommodation and either transfer services into the premises or vacate and take disposal action.

2.24 The extent and cost of compliance with statutory and non-statutory standards (as defined in paragraph 2.13) cannot be ascertained without survey work. The SHHD have issued instructions requiring health boards to undertake surveys as regards compliance with certain standards. However, the Department have not thought it cost-effective to do this for all standards, relying instead on less formal contacts with health boards. Consequently, neither of the two boards visited had investigated the extent to which their properties complied with all the standards, and had not assessed the costs involved for each building. In recent years the Department have undertaken ad-hoc exercises concentrating mainly on fire precautions following a serious fire in Fife in 1981. In response to a SHHD request in 1987, boards assessed the cost of obtaining fire certificates for premises used as offices, shops or factories, at around £1 million. The estimate did not cover premises used for health care services which are outside the remit of the relevant statute.

Part 3: Rationalisation and Disposal of Surplus Land and Buildings

3.1 Rationalisation involves the identification and appraisal of the various possible options for bringing the estate to an optimum size. Unless a comprehensive rationalisation programme is undertaken as an integral part of the strategic planning process there is a danger that surplus land and buildings will be retained or that disposal of the wrong sites will take place. The potential rewards to be obtained from effective rationalisation of the estate are considerable in terms of both revenue savings and sale proceeds.

3.2 The NAO set out to examine whether health authorities and boards had taken action to determine their estate requirements, and had identified the scope for rationalisation. The NAO also examined whether the potential for rationalisation had been put into practical effect, and the level of savings from past and expected disposals.

Audit findings

England

Rationalisation

3.3 The DHSS regard rationalisation as a high priority task, and have asked health authorities to identify surplus property and to dispose of it quickly. During recent years the Department have introduced a range of performance indicators to help health authorities assess and compare their performance with that of others. The NAO found the latest indicators highlighted large variations between authorities in the amount of property held. For example, ignoring extremes, some districts hold five times more land per head of population than others.

3.4 The NAO also found that the DHSS performance indicators pointed to a widespread recognition within the NHS that land held was excessive for present service needs. One-fifth of the districts in England confirmed that at least 40 per cent of their land holdings had been identified as surplus to requirements. One DHA, St Helens and Knowsley, categorised 78 per cent of their land holdings as surplus (Table 1).

3.5 The NAO recognise that variations between health authorities do not necessarily indicate that current property holdings are inappropriate, having regard to service needs. Nevertheless, the wide variations suggest the need for local management to examine the amount of property held. West Midlands RHA had used the performance indicators and had required their districts to verify data and provide explanations. However, the region thought the indicators were possibly suspect because of shortcomings in the processes for information collection.

3.6 The DHSS instructions to health authorities require them to draw on the estate data base to

Table 1

Indicator		Excluding Extremes		
	Lowest	Lowest	Highest	Highest
Land area/1,000 resident population (hectares)	0.07	0.14	0.72	1.38
Building area/bed (m^2)	8	63	121	252
Building area/1,000 resident population (m^2)	38	341	934	2,420
Disposable land as a percentage of total holdings	0%	0.1%	49.6%	77.7%
Plot ratio (ratio of total floor area to total area of sites)	0.04:1	0.1:1	0.4:1	1.53:1

Note: This table demonstrates the variations in the amounts of land and buildings held by health authorities in England. The extremes excluded are the lowest and highest ten per cent.

Source: DHSS Performance Indicators, 1985–86.

prepare comprehensive rationalisation programmes as part of their strategic planning. Although all RHAs have declared firm intentions to rationalise their estate, the NAO found from the planning and review process that only three regions had attempted to quantify the full potential for rationalisation by estimating the extent of their surplus holdings.

3.7 The NAO enquiries at two RHAs suggested that, generally, considerable scope remained to achieve further economies by rationalisation, and there was increasing recognition of this. West Midlands RHA acknowledged that more work was required to maximise the full potential for estate rationalisation; and North Western RHA established in 1986 that nine of their 19 districts had an excessive ratio of land to notional floor area.

3.8 However, the NAO found that management at the district level have not always been fully alert to the scope for rationalisation. For example, at Burnley DHA, acute services have for many years been maintained on five sites, but it was only in mid-1987 that the authority recognised the scope to rationlise these services at one location.

3.9 The NAO examination showed that rationalisation schemes were often dependent upon major capital developments. The pace at which some rationalisation plans are being implemented is therefore slow. For example:

(a) Lancaster DHA maintain acute services on four sites. Various proposals for rationalisation had been under consideration since the early 1970s. In 1984 the authority reaffirmed a policy for the provision of additional ward accommodation at the Royal Lancaster Infirmary which would enable rationalisation of the outlying facilities to take place. Proposals for a capital development were put forward and approved in 1986 and rationalisation of acute services is now expected to take place in 1993. Annual revenue savings estimated at £1.5 million (1984 prices) will not accrue until that date. Other elements of the DHA's programme for rationalisation such as the disposal of the Royal Albert Hospital for the mentally handicapped are not expected to be achieved until after 1998;

(b) proposals for a new District General Hospital at Oldham arose at least 20 years ago since which time the DHA have been working towards rationalisation of services. The first phase of the development, which will allow some rationalisation to take place, is expected to be completed in late 1988;

(c) in 1983–84 Worcester DHA embarked on a development programme to improve local health services. The phase of the programme, involving centralising acute services within the city on one site, is not expected to be completed until 1997. However, the district are now considering some shorter-term rationalisation measures.

3.10 The NAO noted that, in the absence of suitability and use surveys, health authorities have drawn up proposals for new developments without knowing if they are making the best use of their existing facilities. North Western RHA assured the NAO that decisions for new developments had been based on the best information available. They confirmed, however, that their capital programme did not take full account of the rationalisation potential that may flow from a comprehensive appraisal of the estate.

3.11 The NAO found that one DHA had successfully undertaken rationalisation by making better use of their existing facilities without the need for a full-scale capital development. After a review of the functions of smaller hospitals in their authority, Merton & Sutton DHA were able in 1982 to close one hospital and relocate all patients within another. The total cost of the transfer amounted to £1,081,000, but the hospital closure produced annual revenue savings of £319,000 and sale proceeds amounting to £1.8 million. The NAO noted that the Merton & Sutton health authority had subsequently applied a similar approach to two further schemes involving relocation of services and better use of spare capacity elsewhere within the estate. The total expenditure for the transfer of patients and minor capital works amounted to £1.1 million, recurring annual savings of about £1.5 million are expected and disposal proceeds may amount to £8 million.

3,12 In May 1987 the DHSS Property Adviser said that he had seen very little evidence elsewhere of the Merton & Sutton approach working smoothly. Furthermore, the DHSS fully appreciate that the potential revenue savings from, for example, reduced staffing levels, payments in lieu of rates, maintenance, heating and lighting are at least as important as capital receipts from disposals. They have estimated that annual revenue savings from making better use of the estate in England may range between £300 million and £500 million. The DHSS have therefore developed the Merton & Sutton initiative into a case study within their training arrangements (paragraph 4.16).

3.13 It was clear to the NAO that limited funds to finance rationalisation schemes had delayed progress. New capital developments and rationalisation

proposals usually compete for available funds and there is therefore a need for health authorities to co-ordinate decisions on capital and rationalisation schemes. In the two regions the NAO visited only one of the 41 DHAs had developed rationalisation proposals throughout their whole estate. An appraisal by South Warwickshire DHA had identified that rationalisation would produce annual revenue savings of £1 million and would save about £18 million maintenance. But to achieve these savings the district considered that net capital expenditure of £12 million was necessary. However, due to limited resources, West Midlands RHA have been able to provide only £5 million. In an attempt to overcome similar difficulties in the future, the region told the NAO that they aimed to provide limited bridging finance for rationalisation schemes by building up a loan pool of £27 million by 1990–91. The aim was to fund the pool, in the longer term, from savings on rationalisation schemes.

Disposals

3.14 Following earlier PAC concern over the need to identify all surplus NHS land (8th Report of Session 1982–83), the Department have encouraged health authorities to dispose of unwanted property. Proceeds from disposals in England have therefore increased substantially. In 1982–83 annual sales amounted to £18 million and by 1986–87 this had risen to £146 million (Figure 1). The NAO note however that over this period the acreage disposed of has not increased proportionately (Figure 2, page 16). The DHSS Property Adviser considers this may be due to a combination of factors including improvements in disposal arrangements, a greater awareness of the financial value of property and inflation.

3.15 The DHSS currently estimate that annual proceeds from the sale of NHS surplus property will reach £246 million in 1987–88. However, when the Department reviewed the regions' 1986–87 short term programmes they considered some of the individual estimates were unrealistically high whilst others were low. They also recognised that they were not in a position to know whether the estimated sales levels represented satisfactory performance. Although this task falls primarily to regions, the DHSS have acknowledged the importance of reliable estimates and they now plan to monitor regional performance against forecasts of disposals.

3.16 The DHSS have encouraged health authorities to adopt a more commercial approach to property disposal by the involvement of RHAs in development either directly or in partnership with the private sector. Both regions visited by the NAO had established panels to advise on property matters and use external advisers in this role. The NAO examination of disposal cases confirmed that health authorities were regularly seeking expert advice on planning opportunities or on disposal arrangements to increase sale proceeds.

3.17 In reviewing regions' strategic plans, the NAO found that some had expressed concern over difficulties in obtaining planning permission. Both RHAs visited had tried to maintain formal links with local authorities to allow speedier and easier disposal of properties. However, the NAO noted that Green Belt restrictions had on occasions caused significant problems and delays in the disposal of land. For example, in 1982–83 South East Staffordshire DHA had identified some 60 per cent of their estate as potentially surplus but subsequent disposal attempts had been delayed because of Green Belt restrictions. Discussions between the DHSS and the Department of the Environment have resulted in the issue of new guidelines to local authority planning departments in 1987 aimed at clarifying the application of Green Belt restrictions to redundant hospital sites. Whilst the objective of the guidelines is to make it easier for authorities to obtain planning permission, it will not be possible to evaluate their effectiveness for some time.

3.18 Health authorities have to apply approved procedures when closing or changing the use of health buildings. It was clear to the NAO that these procedures can delay the rationalisation and disposal of surplus property. One health authority told the NAO that they considered these procedures expensive, bureaucratic and in need of comprehensive overhaul. As regards the sale of surplus property the NHS Management Board recognised in 1986 the need to free health authorities from unnecessary procedures whilst still preserving public accountability. The DHSS were therefore revising their Land Transactions Handbook at the time of the NAO examination.

3.19 The Ceri Davies report recommended that, as an incentive to rationalise their estate and to take prompt disposal action, DHAs should normally be allowed to retain the full proceeds of sale. However, the NAO observed that the incentive value of current arrangements may be reduced because of the way they are operated by the RHAs visited. North Western RHA retain a proportion of the receipts from sales and two of the DHAs (West Lancashire and Oldham) told the NAO that they regarded this as a disincentive to disposal. However, the RHA informed the NAO that, in their view, it was not equitable to allow relatively over-provided districts to retain all of

Figure 1

Proceeds from the sale of surplus NHS property in England

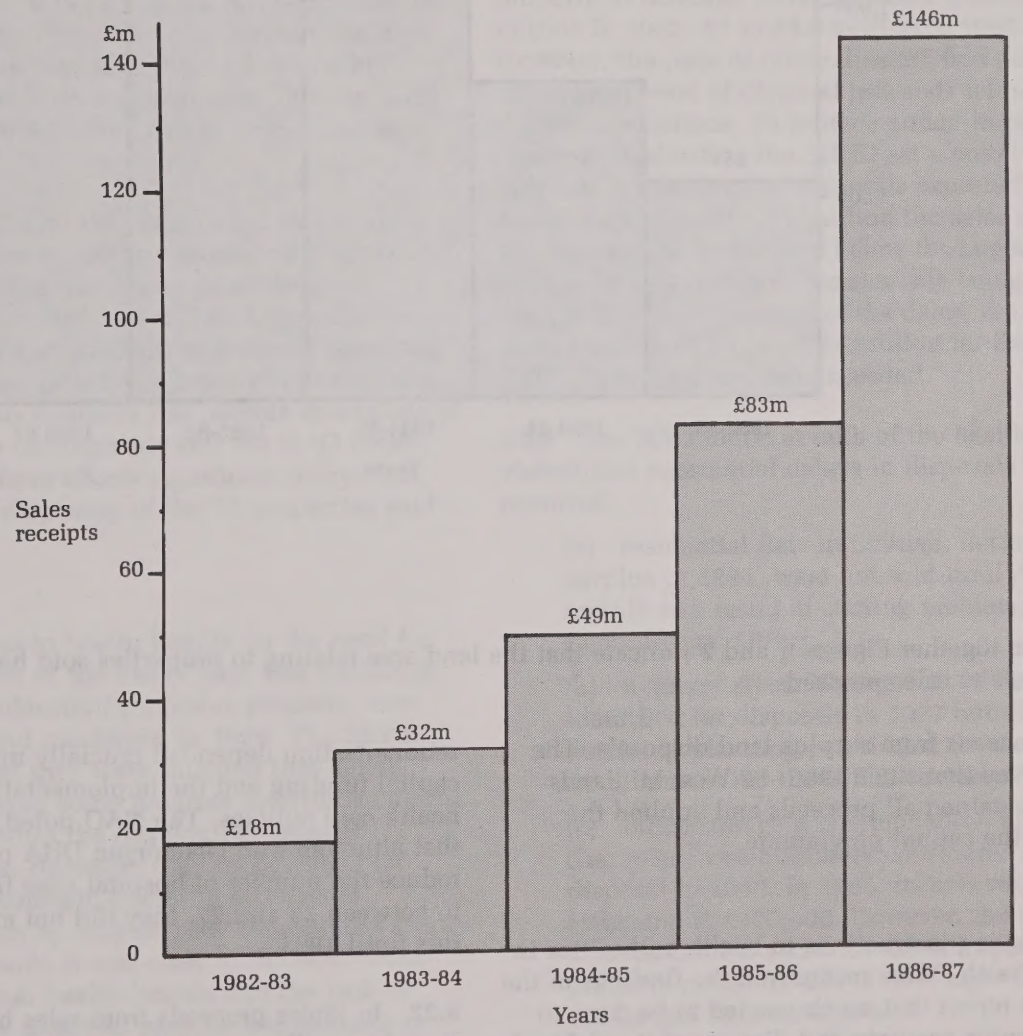
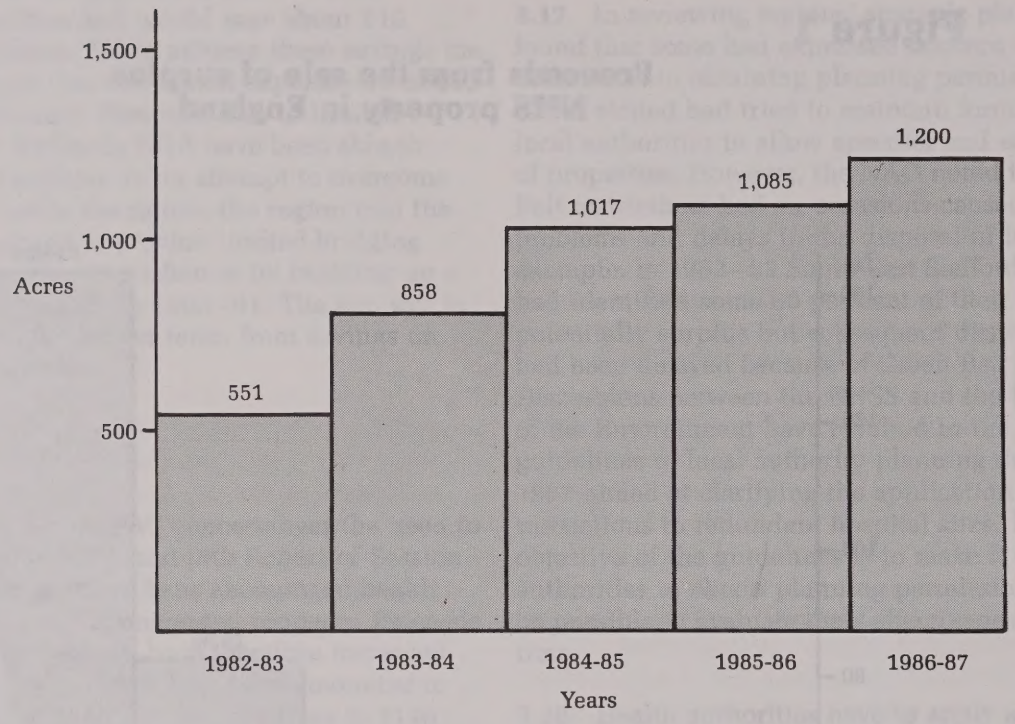


Figure 2

Land area relating to NHS property disposals in England



Note: Taken together Figures 1 and 2 indicate that the land area relating to properties sold has not increased proportionate to sales proceeds.

the sale proceeds from surplus land disposals. The NAO observed that since 1986–87 West Midlands RHA have retained all proceeds and applied the receipts to the capital programme.

Wales

3.20 In issuing instructions to health authorities in 1984, the Welsh Office recognised the findings of the Ceri Davies report that much needed to be done to identify surplus property and dispose of it quickly. In 1986 the Welsh Office reaffirmed that rationalisation of the NHS estate was a high priority task and that their aim was to bring the estate to a size, quality and condition consistent with the needs of the service.

3.21 The NAO found that only five of the nine Welsh DHAs had made specific mention in their strategic plans of proposals to slim down the estate. It was evident, however, that the pace of rationalisation depended crucially upon the level of capital funding and the implementation of national health care policies. The NAO noted, for example, that although Mid Glamorgan DHA proposed to reduce the number of hospital sites from 34 (in 1984) to between 23 and 27, they did not expect to achieve this until 1993.

3.22 In Wales proceeds from sales have increased from £1.4 million in 1982–83 to £2.7 million in 1986–87. Disposal procedures are similar to those in England, but the Welsh Office handle some of the larger or more complex property transactions. Authorities retain the proceeds of sales except where the disposal has been made possible by centrally allocated capital funds.

3.23 The NAO noted that the Welsh Office and DHAs have on occasions experienced difficulties in

the disposal of some properties. At Mid Glamorgan, for example, one hospital had been vacated in 1983 but had not yet been disposed of because of difficulties in agreeing amendments to restrictive terms of the lease with the freehold owners. It is expected that disposal will take place during 1989. Due to the delay, some £222,000 had been incurred on maintenance and security of the empty building.

3.24 The NAO also found evidence which suggested that surplus land was being retained by one DHA in the hope that sales values might improve. Four parcels of land amounting in total to some 63 acres in Powys had been identified as surplus to requirement in 1982. The land was first placed on the market in 1984 for sale by auction but only attracted offers below the reserve price. Subsequent attempts to sell it in 1985 and 1986 also resulted in low bids. The land has been withdrawn from the market until at least Spring 1988 in the hope of increasing its disposal value.

3.25 The NAO found that East Dyfed had made strong and positive efforts to ensure that disposal action is achieved as quickly as possible after properties are identified as surplus. Disposal is an integral part of the authority's operational planning and, as such, is subjected to annual internal review. The authority also regularly use outside specialists to assist and advise on disposals and the NAO noted that because of these efforts significant delays had been avoided in disposing of the 18 properties sold since 1982–83.

Scotland

3.26 Instructions to health boards on the need for continuous review of the use of land and buildings, with the aim of identifying surplus property, were issued in 1984 and reinforced in 1986. The SHHD told the NAO that they were satisfied that health boards were making some progress towards including estate matters within the developing strategic planning process. However, they recognised that none of the ten strategic planning statements submitted to them by August 1987 represented a fully integrated approach. It was clear to the NAO from visits to individual health boards that the lack of some basic estate data had been an impediment to full rationalisation. For example, although Lothian Health Board had undertaken annual exercises to identify surplus property, they appreciated that they were to an extent hampered by the absence of up to date information on suitability and use.

3.27 It was also clear that the larger and more complex the planned rationalisation the greater the delay in its achievement and thus the disposal of property released. For example, in 1983 the Lothian Health Board envisaged a reduction from 13 to 5 in the number of acute hospitals. But this could not be achieved until the year 2000.

3.28 The proceeds from the sale of surplus NHS property in Scotland have increased from £1.8 million in 1982–83 to £3.6 million in 1986–87. However, the pace of rationalisation and the consequent level of disposal proceeds fell short of the SHHD expectations. To provide added impetus to estate rationalisation the SHHD set a target in 1986–87 for the level of disposals expected of each health authority. At £3.6 million the sales achieved in 1986–87 fell 30 per cent below the target of £5 million largely due to one major sale being delayed until 1987–88. As a result of the delay, the SHHD expect that their target of £7 million for the year 1987–88 will be met and exceeded.

3.29 The NAO found at both of the health boards visited that substantial delays in disposals had occurred:

(a) residential flats in Lothian, declared surplus in 1984, were not sold until April 1987 mainly as a result of staffing problems at the Central Legal Office;

(b) a quarry site in Grampian had been identified for disposals in 1977 but difficulty in obtaining planning permission for residential development led the SHHD to delay the sale;

(c) office/storage accommodation, also in Grampian, was originally considered for disposal in 1980. In 1985, its sale value was estimated at £300,000. However, the property remains unsold and with the fall in local property prices its sale is now expected to realise less than £200,000.

Part 4: Development of Strategies for Maintaining the Retained Estate in an Adequate Condition

4.1 The establishment of a reliable estate data base (Part 2), the rationalisation of the estate and the disposal of surplus land and property (Part 3) are essential to the process of sound estate management. It is then vital that strategies are developed for maintaining the retained estate in an adequate condition. It is also important that responsibility for estate matters within health authorities and boards is vested in officers at a sufficiently senior level; and that all staff concerned receive appropriate training.

4.2 The NAO set out to examine whether health authorities and boards had developed strategies for maintaining the retained estate. They also examined whether the training arrangements met the needs of the professional and managerial staff with responsibilities for estate matters.

Audit findings

England

Maintenance

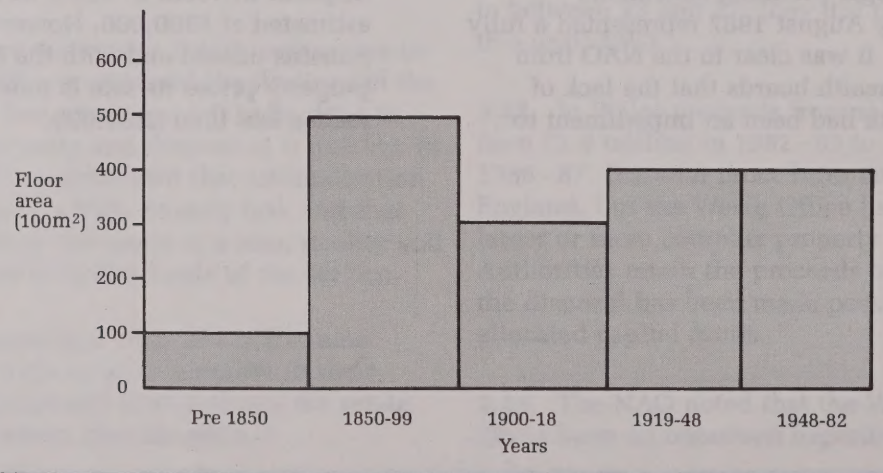
4.3 Despite significant capital investment on new developments in recent years, the NHS estate in England largely consists of property dating from before the NHS was formed in 1948. And over a third was built before the start of the century (Figure 3).

4.4 It is therefore not surprising that substantial maintenance commitments are involved. The Ceri Davies report had expressed concern over the level of outstanding, or "backlog" maintenance. On the evidence of a sample survey in one region in 1982 the report estimated that it would cost about £2 billion to bring NHS properties in England to a level regarded by health authorities as the minimum acceptable standard. The NAO noted that the DHSS have not specifically monitored the overall level of expenditure required to clear backlog maintenance and do not know if the position has improved or deteriorated since the £2 billion assessment was made. The NAO appreciate that any assessment of backlog maintenance is meaningless without up to date knowledge of the condition of the estate and until decisions have been made on which areas of the estate are to be retained.

4.5 The NAO examined the latest strategic plans and short-term programmes of regions and found that concern over the level of backlog maintenance was a central theme. Several regions pointed to shortfalls in funding and the consequent growth in backlog maintenance which would inevitably lead to an increased need for resources in the future. However, only four regions had set specific targets for reductions in backlog maintenance by 1995.

Figure 3

Age of NHS property in England in 1982



4.6 The condition of the NHS estate in England is assessed by the DHSS under four categories as detailed in Table 2.

Table 2

DHSS categorisations of the condition of NHS property

Condition A	— is as good as new
Condition B	— is adequate with only minor deterioration
Condition C	— is such that the accommodation is operational but repairs are required to restore the accommodation to Condition B
Condition D	— is such that the accommodation is inoperable or unacceptable; major or costly repairs will be necessary to raise accommodation to Condition B

As a target, the DHSS established in 1985 that a minimum of 70 per cent of the NHS building stock should be in at least adequate condition, ie categorised as Condition A or B.

4.7 Whilst only 113 of the 191 DHAs supplied the required data to the DHSS, the Department's latest (1985–86) performance indicators provide some measure of the position. Of the 113 DHAs, 60 fell short of the target. The performance indicators also suggest that large variations exist between DHAs in the condition of their estate holdings (Table 3). The NAO noted that variations were particularly pronounced between regions. For example, within West Midlands and Mersey RHAs only one of 29 districts achieved the DHSS 70 per cent target, whereas 21 out of the 26 districts in Trent and North West Thames RHAs achieved it.

4.8 The NAO found that estimates of backlog maintenance also varied widely between the two RHAs visited. North Western RHA estimated that their backlog was no more than £20 million, although they told the NAO that £53 million may prove a more realistic assessment of the cost of bringing the estate up to Condition B. West Midlands RHA estimated that their backlog amounted to £300 million and that despite a large capital programme this was unlikely to reduce before 1996. Wide variations in estimates of backlog maintenance also existed among DHAs visited by the NAO. For example, at Oldham the backlog had been assessed at only £1.4 million, whilst at Central Birmingham it had been put at £34 million.

4.9 Given the level of backlog maintenance and the poor condition of some of the building stock, the

Table 3

Analysis of returns by DHAs of the condition of property

Proportion of property categorised as falling within DHSS defined condition	Lowest	Excluding extremes Lowest	Excluding extremes Highest	Highest
Percentage in Condition A	0	0	18	65
Percentage in Condition B	2	7	85	94
Percentage in Condition C	0	10	84	97
Percentage in Condition D	0	0	11	59

Note: The table shows the range of percentages in the four DHSS categories. For example, of those districts with properties in Condition A, the range varied from 0 per cent to 65 per cent.
Source: DHSS Performance Indicators, 1985–86.

Table 4

	Lowest	Excluding extremes Lowest	Highest	Highest
Maintenance cost/building area (m^2)	£6	£9	£18	£27
Cost/Unit area to reach condition B (m^2)	£3	£9	£114	£216

Source: DHSS Performance Indicators 1985–86.

NAO was not surprised to find that local management was concerned about the safety and wider value for money implications. For example, Central Birmingham DHA considered that further delay in replacement or repair inevitably introduced unacceptable risks to safety and essential services. The NAO observed that since 1980–81 professional staff had argued that maintenance levels were below the standard necessary to ensure the safety of the estate. West Midlands RHA have emphasised to the district that the present scale of the maintenance problem would have been avoided if adequate priority had been given to preventive maintenance in the past.

4.10 Within the West Midlands RHA the NAO found an example where poor value for money had resulted from maintenance not being undertaken when due. The flat roofs on a hospital in Central Birmingham had been repeatedly patched rather than replaced in the early 1980s because of restrictions on the funds allocated to estate maintenance. However, this resulted in substantial water damage and additional expenditure of about £1 million is now needed to effect repairs which otherwise would not have been necessary.

4.11 The NAO examination at the two RHAs suggested that each had different approaches and priorities for tackling backlog maintenance and meeting the DHSS condition targets:

(a) North Western RHA recognise that it is unwise to use targets which have not been integrated with service and financial objectives. However they have considered targets helpful in the review process and as a means of ensuring that the estate was adequately maintained. Accordingly districts in that region were asked to aim for a target spend of 9 per cent of their revenue and 50 per cent of their capital allocation on estate maintenance;

(b) despite significantly greater problems with backlog maintenance, West Midlands RHA had not set their districts specific targets for the level of maintenance expenditure. Instead, they had required districts to set out how they would meet their future maintenance commitments. However, the NAO found that this work had not been completed by all districts. Some of the districts which had completed this work had based their analyses on condition surveys which were several years old and of doubtful accuracy.

4.12 More generally, the NAO noted that the 1985–86 expenditure on maintenance expressed as a proportion of revenue expenditure, varied between DHAs. It ranged from 2.9 per cent to 6.7 per cent. The DHSS performance indicators revealed that the levels of maintenance expenditure per unit area of property holdings varied fivefold, and that the variation in costs to bring the estate up to an acceptable condition was far greater (Table 4).

4.13 Health authorities are required to prepare long-term (strategic) plans and short-term (operational) programmes which link service objectives with the three resources of finance, manpower and the estate. The DHSS accepted the need identified in the Ceri Davies report for estate proposals to be drawn together by health authorities into estate control plans. In this context, the NAO found that:

(a) the DHSS had expressed concern that the latest plans and programmes of 11 of the 14 RHAs had failed to indicate that estate considerations had been fully integrated into service plans. Only five regions had reported in their 1984–85 strategic plans any progress on preparing estate control plans. Although one of these, Trent RHA, had reported that such plans had been completed by all of its districts, they subsequently acknowledged in their 1986–87 short-term programme that the estate data base was still incomplete;

(b) although a few estate control plans had been produced for individual sites, only one of 41 DHAs within the two regions visited had drawn up a full rationalisation programme and an estate strategy. North Western RHA told the NAO that in the absence of national guidance and models (promised by the DHSS in 1983), they had recently attempted to develop their own methodology based on a pilot exercise in one district. Regional guidance had been issued in March 1987 with the aim of ensuring estate

control plans are prepared by mid-1988 for sites subject to change. The programme for completing the remaining sites will be subject to review.

Management arrangements and training

4.14 The NHS Management Board recognise the crucial importance of ensuring an adequate awareness of estate matters within health authorities. They appreciate that this can only be achieved if properly trained staff (including some with commercial experience) operate within an appropriate management structure. They were therefore particularly concerned to be told by their Property Adviser in 1986 that there had been virtually no systematic review of health authorities' performance at national level. He could give no more than a highly impressionistic account of how particular RHAs were performing. Consequently the DHSS established a monitoring unit within their Estate Directorate to visit all RHAs in 1986 and 1987 to assess the local awareness of estate issues and evaluate whether RHAs were providing appropriate leadership to DHAs.

4.15 The unit found that regions were generally starting to take estate and property matters seriously and becoming aware of the estate as a resource. The NAO noted, however, that some important weaknesses had been identified by August 1987. The DHSS had concluded that a number of regions lacked proper in-house property expertise at the right level. Some RHAs appeared to have inadequate practical experience of surveying, and regional Land and Property panels did not always include people with current knowledge of the property market. The unit was concerned that not all regions were taking proper account of the estate in their strategic planning. They also felt that the lack of sustained action to improve the performance of the estate was partly due to the resources applied to the work.

4.16 The initiatives flowing from the Ceri Davies report covered many new principles with which health authorities needed to be familiar. Most training for estate management is provided by the Hospital Estate Management Engineering Centre which is part of the NHS Training Authority and is available to all NHS staff throughout the United Kingdom. The centre provides a range of courses on estate matters including a series developed jointly by the DHSS and the NHS Training Authority to provide training on the interaction between service planning and estate management. Although the series has been strongly endorsed by the Department, at the time of the NAO audit, officers from only 40 of the 191 DHAs had undertaken the training. The NAO also noted that at the time of their examination only one of the 22 districts in West Midlands region had completed the course.

4.17 The NAO examination revealed that in 1986 the training centre had been reviewed by external consultants who had identified fundamental shortcomings. A plan was prepared to remedy the identified shortcomings and, in recognition of the need to provide a more comprehensive approach to estate management training, the DHSS in conjunction with the NHS Training Authority are developing a new training programme. Short courses have been developed for presentation locally to improve awareness among estate managers of key issues and relevant guidance.

Wales

4.18 As a result of their review of the 1983–84 strategic plans the Welsh Office were concerned that backlog maintenance was estimated at £118 million. They encouraged DHAs to provide a minimum of 7.5 per cent of their total financial allocation to the maintenance or renovation of their assets, including buildings, vehicles and equipment. The Welsh Office acknowledge that they have been unable to monitor whether this level of expenditure was achieved in practice. However, in connection with their 1988 programme of reviews of DHA performance, they have required authorities to provide additional information concerning maintenance expenditure. The NAO found that both DHAs visited had broadly met the 7.5 per cent target, although one considered the target too low to cover minimum maintenance requirements.

4.19 In East Dyfed the NAO found a particular awareness of the need to ensure that maintenance expenditure provided sound value for money. Consultants had been commissioned to assess the appropriate level of resources for maintenance of the estate. They had concluded that funds allocated at the unit level did not currently reflect need and suggested that savings of £190,000 could be achieved through improved management arrangements.

4.20 Neither of the two DHAs visited had prepared estate control plans. The NAO noted that, whilst the strategic management of the estate did not feature specifically in strategic plans, estate issues had been increasingly raised by the Welsh Office during the review process. Also, they had jointly sponsored with three districts strategic reviews of the planning link between patient services and the estate.

Scotland

4.21 A survey undertaken in 1980–81 indicated that backlog maintenance in the NHS in Scotland amounted to £205 million (£288 million at 1986–87 prices) and that greater investment in maintenance was required. Consequently, in 1983 the SHHD introduced a special annual allocation of funds against which health boards were allowed to bid. The main aim was to remove backlog maintenance within 10 years and to date some £85 million has been spent through this process. Although the SHHD said in 1983 that they planned to monitor the performance of boards on improving their properties, they recognised in 1986 that their lack of monitoring left them in a very vulnerable position. Accordingly, the SHHD undertook detailed technical monitoring of a selection of completed projects to ensure that special allocation funds had been spent on eligible schemes. The Department plan to repeat this exercise for projects completed in 1986–87. In January 1988 they were still considering whether from 1988–89 boards should only be permitted to spend their special allocation on improvements identified as necessary in the 1986–87 condition survey.

4.22 The NAO noted that, despite the special allocations of funds, the 1986–87 condition survey indicated that backlog maintenance had increased to an estimated £359 million. The reasons for the increase will become clearer when the SHHD validate the outcome of the survey. The NAO noted that a Scottish NHS review team had recently found that the general condition of NHS buildings was unsatisfactory and that maintenance was inadequate.

4.23 In 1986 the SHHD emphasised that a broad knowledge of the condition of the estate and the related maintenance liability was essential to strategic planning. The SHHD acknowledge that this process is at a relatively early stage of development in Scotland, and that none of the strategic planning statements submitted by health boards by August 1987 had explicitly addressed the question of the management of the complete estate (paragraph 3.26). The NAO noted that the Scottish Health Management Efficiency Group had similarly commented on the scope for improvements in planning.

4.24 In March 1987, the Scottish Affairs Committee reported on their inquiry into hospital building in Scotland. On estate management they commented that Scotland had not so far developed effective property management to the same extent as England and Wales, and this had resulted in poor maintenance standards within some Scottish hospitals. They saw a need for the SHHD to impress upon health boards the requirements for good estate management and for planned maintenance policies for new as well as existing property. They considered that estate management should be integrated closely with finance and manpower, and that health boards should recognise the importance of estate considerations in their health planning strategies.

Glossary of Abbreviations

DHA	District Health Authority
DHSS	Department of Health and Social Security
NAO	National Audit Office
NHS	National Health Service
PSA	Property Services Agency
RHA	Regional Health Authority
SHHD	Scottish Home and Health Department
WHCSA	Welsh Health Common Services Authority

Reports by the Comptroller and Auditor General Session 1987 – 88

The Comptroller and Auditor General has to date, in Session 1987 – 88, presented to the House of Commons the following reports under Section 9 of the National Audit Act, 1983:

Department of Energy: Sale of Government Shareholding in British Gas plc ..... HC 22
Ministry of Defence and Property Services Agency: Control and Management of the Trident Programme ..... HC 27
Department of Transport: Sale of Government Shareholding in British Airways plc ..... HC 37
Review of the Operations of HM Land Registry ..... HC 39
Financial Support for the Fishing Industry in Great Britain ..... HC 88
Department of Transport: Regulation of Heavy Lorries ..... HC 92
Home Office Prison Department: Objectives, Organisation and Management of the Prison Service Industries and Farms ..... HC 93
Community Care Developments ..... HC 108
Computer Security in Government Departments ..... HC 111
Overseas Development Administration: Technical Co-operation (Manpower Aid) ..... HC 129
Use of Operating Theatres in the National Health Service ..... HC 143
Ministry of Defence: Sale of Royal Ordnance plc ..... HC 162
Objectives and Management of Ordnance Survey ..... HC 177
Ministry of Defence: Costs and Financial Control of British Forces Germany ..... HC 236
Department of Trade and Industry: Sale of Government Shareholding in Rolls-Royce plc ..... HC 243
External Trade Measures for Agricultural Produce ..... HC 275
Industry Department for Scotland: Review of Scottish New Towns ..... HC 276
Department of Transport: Sale of Government Shareholding in BAA plc ..... HC 312
Department of Trade and Industry, Scottish Office and Welsh Office: Arrangements for Regional Industrial Incentives ..... HC 346
Customs and Excise Department: Investigations of Fraud and Smuggling ..... HC 347
Ministry of Defence: Transfer of the Royal Dockyards to Commercial Management ..... HC 359
Management of the Collections of the the English National Museums and Galleries ..... HC 394
Department of Trade and Industry: The Alvey Programme for Advanced Information Technology ..... HC 402
Estate Management in the National Health Service ..... HC 405

Printed in the United Kingdom for Her Majesty's Stationery Office. Dd 501512, 4/88, C15, 3382, 5673, 12445.

HMSO publications are available from:

HMSO Publications Centre
(Mail and telephone orders only)
PO Box 276, London, SW8 5DT
Telephone orders 01-622 3316
General enquiries 01-211 5656
(queuing system in operation for both numbers)

HMSO Bookshops
49 High Holborn, London, WC1V 6HB 01-211 5656 (Counter service only)
258 Broad Street, Birmingham, B1 2HE 021-643 3740
Southey House, 33 Wine Street, Bristol, BS1 2BQ (0272) 264306
9–21 Princess Street, Manchester, M60 8AS 061-834 7201
80 Chichester Street, Belfast, BT1 4JY (0232) 238451
71 Lothian Road, Edinburgh, EH3 9AZ 031-228 4181

HMSO's Accredited Agents
(see Yellow Pages)

And through good booksellers

ISBN 0 10 240586 3